GERIATRIC MENTAL HEALTH AND MEDICATION TREATMENT

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GENERAL DISCLOSURES

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SPEAKER DISCLOSURES

✓ Any conflicts of interest? Nope
OBJECTIVES

1. Differential diagnosis in the older patient with cognitive complaints.

2. Differential diagnosis of neuropsychiatric symptoms in the older patient (dementia vs. delirium vs. primary psychiatric disorder).

3. Treatment approach with older patients – what are the differences to younger patients?
...A TYPICAL DAY AT THE (MY) OFFICE

“Doc, my memory is going bad. I am worried I have Alzheimers.”

What are the possibilities?

• Worried well
• Medical problem
• Psychiatric problem
• Dementia
**MOCA** – best short test (20 minutes), includes a visual-spatial component

**Mini-cog** – shortest test (3 minutes) for the hurried PCP, tells you “something is seriously wrong”, but false negative for mild cognitive change
- Sum all subscores listed on the right-hand side. Add one point for an individual who has 12 years or fewer of formal education, for a possible maximum of 30 points.

- A final total score of 26 and above is considered normal.

- Ruth’s rule: a good MOCA (20 min) gives you about 2/3 of the information of a 2-4 hour neuropsychological test battery.

- Information is not only contained in the absolute score, but also in the pattern of deficits.
65-year old man with a MOCA of 27...

“That’s great, doc, but I am still not the man I used to be. My wife tells me I am forgetting things.”

Why?
Most cognitive abilities decline linearly throughout the life span – two standard deviations of decline in processing speed and memory retrieval.

Summary

PRACTICAL IMPLICATIONS OF NORMAL AGE-RELATED COGNITIVE CHANGE:

• As (usually high-functioning) middle-aged patients become aware of age-related change, they may present with anxiety, depression, and concerns about dementia.

• Age-related cognitive change leads to a reduction in cognitive reserve, which makes patients vulnerable to the cognitive impact of other medical or psychiatric conditions.
• The majority of children with ADHD continue to have ADHD as adults.
• Some middle aged patients become symptomatic when they can no longer multitask rapidly.
• Patient present with depression, anxiety, feeling overwhelmed.

We think of ADHD as a disease of children, but sometimes patients are first diagnosed in their 60s or 70s.
AGING + DEPRESSION

• Higher vulnerability to the cognitive impairment associated with depression, hence depressive “pseudodementia” – BUT: unless the patient is catatonically depressed, depression alone accounts for no more than ~4 points loss on the MOCA.

• “Scattered” deficits on an almost normal MOCA.
ABNORMAL MOCA...WHAT NOW?

• Rule out medical problems with “memory labs”: complete metabolic panel, CBC, B12, folate, TSH, HIV, syphilis.
• Review the timeline of change: very rapid deterioration suggests delirium, search for an underlying cause (e.g. UA).
• Review medications, stop anticholinergic medications (e.g. oxybutynin, benadryl), reduce sedating medications.
• Brain MRI in some cases - do if change has been rapid, diagnosis unclear, and a recent fall is possible (r/o subdural hematoma).
• (Neuropsychological testing)
DELIRIUM

Dementia

• Gradually and slowly progressive over months to years
• Minor fluctuations over the course of the day or weeks

Delirium

• Sudden onset – anything sudden onset in an older person is delirium unless proven otherwise
• More dramatic fluctuations
• Look for: recent medication change or acute illness.
“REVERSIBLE” CAUSES OF DEMENTIA

- Depression
- Hypothyroidism
- Medications
- General medical illness (e.g. B12 deficiency)
- Sleep apnea

- Sleep study – OSA does not have much effect on cognition
- D/C psychotropic medications (gabapentin, antidepressants, mood stabilizers, benzodiazepines, antipsychotics)
THE DEMENTIAS

• Alzheimer’s disease
• Dementia with Lewy bodies
• Parkinson’s disease dementia
• Vascular dementia
• Frontotemporal dementia
ALZHEIMER’S DISEASE – MOST COMMON
(1/3 OF PEOPLE OVER AGE 85)

Key presenting symptoms

- Strongly reduced ability to make new memories, leading to:
  1. Repeated identical questions
  2. Re-telling the same story multiple times
- Word finding difficulties
- Giving up prior activities (socializing, reading, housework, computer)

...often misdiagnosed as:

- Depression
  Family members wonder about depression as the cause of social withdrawal or reduced engagement in activities.
- Inattention
  Spouses complain about their husband/wife not listening to them.
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Typical MOCA pattern

Rhinoceros - Hippo
DEMENTIA + PARKINSON’S

Lewy Body Dementia

• Dementia precedes the onset of Parkinson symptoms.
• Strongly fluctuating symptoms (DD – psychiatric/volitional)
• REM sleep disturbance (DD – nightmares)
• Visual hallucinations (DD – psychotic illness)
• More pronounced visual-spatial deficits than in “pure AD”.

Parkinson’s Dementia

• Parkinson symptoms precede the onset of dementia.
BIZARRE VISUAL SYMPTOMS IN A MIDDLE-AGED OR OLDER PATIENT:

- Visual hallucinations – psychosis vs. dementia with Lewy bodies
- Posterior cortical atrophy variant of Alzheimer’s disease: younger onset than regular AD, may present with visual symptoms such as bizarre visual distortions, being unable to recognize objects, loss of ability to read - often misunderstood as eye problem or factitious disorder. Visual-spatial difficulties on the MOCA.
VASCULAR DEMENTIA

- Destruction of brain tissue by cerebrovascular disease
- More varied presentation than Alzheimer disease – scattered deficits on the MOCA
- Often co-occurs with Alzheimer disease
FRONTOTEMPORAL DEMENTIA

• Can affect patients as young as age 35.

• Behavioral variant vs. progressive aphasia.

• Behavioral variant is often misdiagnosed as bipolar disorder, personality disorder, depression.

• Prominent symptoms (differ by patient): disinhibition, impulsivity, hyper-sexuality, change in food preference to sweet or salty snacks, loss of empathy, apathy, psychomotor slowing.

• Marked personality change usually precedes marked cognitive change.
NEUROPSYCHIATRIC SYMPTOMS OF DEMENTIA

- Depression
- Anxiety
- Apathy
- Delusions
- Hallucinations
- Psychosis
- Irritability
- Agitation
- Wandering
- Elation
- Sleep problems

TREATMENT OPTIONS

Cognitive symptoms

• Cholinesterase inhibitors (e.g. donepezil, rivastigmine patch): AD, dementia with Lewy bodies
• Memantine: moderate to advanced AD

Behavioral symptoms

• Antidepressants
• Antipsychotics (low dose quetiapine, risperidone – cost is an issue; risk of increased mortality in older patient with dementia)
• Prazosin for agitation (up to 8 mg in divided doses)
• Mood stabilizers (e.g. lamotrigine, depakote)
HOW IS MEDICATION MANAGEMENT DIFFERENT IN THE OLDER PATIENT?

• Avoid **benzodiazepines** if possible – risk of worsening confusion and agitation, risk of falls.

• Reduce **anticholinergic** load (Beers list).

• Check all older patients on SSRIs for **hyponatremia** (q 6 months).

• Risk of **QT prolongation** (citalopram).

• Much higher prevalence of **sexual side effects on SSRIs** and SNRIs (use mirtazapine or bupropion, possibly vilazodone, in older men,).

• Consider impaired clearance due to kidney or liver disease.
ELEMENTS OF CARE IN DEMENTIA

• Involvement of care giver(s): screening for caregiver burden and/or depression – training of care givers in behavioral interventions
• Ties to community agencies for additional support (e.g. Alzheimer’s Association)
• Care is more challenging (NPS are often treatment-resistant)
• More limited psychotherapeutic approaches (behavioral activation, pleasant events)
CARE PARTNER INVOLVEMENT

• Education about cognitive impairment
• Psychological assessment of the care partner and referral to psychiatric care as needed
• Referral to community support http://www.alz.org/, http://www.thearftd.org/
• Teaching care partners about realistic expectations, good communication, problem solving, and pleasant events